

Part III. Patients' Compensation Fund Oversight Board

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Title 37

INSURANCE

Part III. Patients' Compensation Fund Oversight Board

Chapter 1. General Provisions

§101. Scope

A. The rules of Part III provide for and govern the organization, administration, and defense of the Patients' Compensation Fund (the fund or PCF) by the Louisiana Patients' Compensation Fund Oversight Board (the board), within the Office of the Governor; the requirements and procedures for enrollment with the fund by qualified health care providers; the maintenance of required financial responsibility and continuing enrollment with the fund by enrolled health care providers; record keeping, accounting, and reporting of claims and claims data by the fund and enrolled health care providers; and defense of the fund and the payment of judgments, settlements and arbitration awards by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§103. Source and Authority

A. These rules are promulgated by the board to provide for and implement its authority and responsibility to administer and defend the Patients' Compensation Fund pursuant to the Louisiana Medical Malpractice Act (the Act), R.S. 40:1299.41-1299.48.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§105. Patients' Compensation Fund: Description

A. The Patients' Compensation Fund is a special fund established by R.S. 40:1299.44, funded by surcharges paid by private health care providers enrolled with the fund, to provide just compensation to patients suffering loss, damages, or expense as the result of professional malpractice in the provision of health care by health care providers enrolled with the fund, when and to the extent that a judgment or settlement or a final award in an arbitration proceeding is in excess of the total liability of all liable health care providers, as provided by and subject to the limitations of R.S. 40:1299.42. Such fund, therefore, comprises monies held in trust as a custodial fund by the state for the use, benefit, and protection of medical malpractice claimants and the fund's private health care provider members. Responsibility and authority for administration and operation of the fund including, but not limited to, the evaluating, establishing reserves against,

defending, and settling claims against the fund, applying to the Louisiana Insurance Rating Commission, on the basis of annual actuarial studies, for surcharge rates or rate changes, and administering medical review panel proceedings under R.S. 40:1299.47, is vested in the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§107. Purpose and Objective of Rules; Construction, Application

A. These rules are adopted and promulgated to ensure that the Patients' Compensation Fund is organized, administered, and operated on a financially and actuarially sound basis so as to achieve the purpose for which it was established, by providing that qualification for enrollment is based on sound and realistic standards of financial responsibility; that the fund and its surcharge rates are adequate for the risks assumed; that surcharges are timely collected; that surcharge rate filings are based on reasonably current and complete claims experience data; that actual and potential claims against the fund are timely reported; that reserves against claims are properly established; that the fund is properly defended against improper, unjustified, and excessive claims; and that the fund is responsible and accountable to the patients for whose benefit it exists and to its enrolled health care providers. These rules shall be construed, interpreted, and applied so as to achieve such purposes and objectives.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§109. General Definitions

A. As used in these rules, the following terms shall have the meanings specified:

1. Terminology Definitions

Act—the Louisiana Medical Malpractice Act, Act 1975, Number 817, as amended, R.S. 40:1299.41-1299.48.

Board—the Louisiana Patients' Compensation Fund Oversight Board established pursuant to R.S. 40:1299.44 .D.

Executive Director—the Executive Director of the Louisiana Patients' Compensation Fund Oversight Board, as designated, appointed, and delegated authority pursuant to §303.

2. Coverage Definitions

Claims-Made Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which both occurred and was reported during the effective period of qualification with the fund. Provider must meet all requirements for continued qualification.

Extended Reporting Endorsement—tail coverage.

Occurrence Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which occurred during the effective period of qualification, regardless of whether the provider was actively enrolled on the date on which the claim was reported. Provider must meet all requirements for continued qualification.

Self-Insured Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which occurred during the effective period of qualification, regardless of whether the provider was actively enrolled on the date on which the claim was reported. Provider must meet all requirements for continued qualification.

Tail Coverage—an endorsement which, when purchased by a provider at the end of his claims-made coverage period, provides coverage for a claim arising from an incident which occurred during the effective period of enrollment but was reported following the termination of active enrollment. Provider must meet all requirements for continued qualification.

3. Provider Definitions

Enrolled Provider—an enrolled provider is one who has met the requirements for qualification in the Louisiana Patients' Compensation Fund (including the financial responsibility requirements of R.S. 40:1299.42) who also:

- i. is currently actively involved in medical practice and/or providing medical services in Louisiana; and
- ii. has paid the appropriate surcharge for such practice to the fund for their current policy year.

Qualified Provider—any provider who has met the statutory requirements for malpractice coverage with the Louisiana Patients' Compensation Fund. Qualified providers may be currently either active or inactive in the practice of medicine in Louisiana, depending on the dates for which they are qualified. So long as the financial responsibility requirements for continued qualification are met, a provider need not be currently enrolled in the PCF.

4. General Definitions

Accept or Collect—with reference to the acceptance or collection of payments of applicable surcharges for enrollment with the fund, such surcharges will be deemed to have been *accepted* or *collected* by the commercial professional health care liability insurance companies and approved self-insurance trust funds when the first agent,

employee, representative, or other person acting or purporting to act on behalf of the insurer or the trust fund who has the responsibility to process such surcharges accepts delivery of same.

Disability—for purposes of determining eligibility for the provisions of §715.D of these rules, the inability to continue the practice of medicine due to a permanent illness, injury, or physical impairment. However, for purposes of consideration for a waiver under the provisions of §715.C.3 of these rules, *disability* may also include any permanent illness, injury, or physical impairment which prevents a provider from continuing the practice of his existing medical specialty, surgical class, or risk rating classification as provided in §705 of these rules, whether or not such disability prevents the provider from engaging in the active practice of medicine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 23:68 (January 1997), LR 29:344 (March 2003).

§111. Interpretive Definitions

A. As used in these rules and in the Act, the following terms are interpreted and deemed to have the meanings specified.

Certified Nurse Assistant—a certified nurse aide certified by the Board of Examiners of Nursing Facility Administrators, pursuant to R.S. 37:2504, as amended.

Certified Registered Nurse Anesthetist—a registered nurse who administers any form of anesthetic to any person in Louisiana in accordance with the conditions specified by R.S. 37:930, as amended.

Chiropractor—a person holding a license to engage in the practice of chiropractic in the state of Louisiana, pursuant to R.S. 37:2801-2830, as amended.

Dentist—a person holding a license to engage in the practice of dentistry in the state of Louisiana, pursuant to R.S. 37:751-793, as amended.

Licensed Practical Nurse—a person holding a license to engage in the practice of practical nursing in the state of Louisiana, pursuant to R.S. 37:961-979, as amended.

Non-Profit Cancer Treatment Facility—a non-profit facility considered tax-exempt under §501(c)(3), *Internal Revenue Code*, pursuant to 26 U.S.C. §501(c)(3), for the diagnosis and treatment of cancer or cancer-related diseases, whether or not such a facility is required to be licensed by this state.

Nurse Midwife—a registered nurse certified by the Louisiana State Board of Nursing as a certified nurse midwife.

Nursing Home—a private home, institution, building, residence or other place, licensed or provisionally licensed

by the Department of Health and Hospitals, pursuant to R.S. 40:2009.2, as amended.

Optometrist—a person holding a license to engage in the practice of optometry in the state of Louisiana, pursuant to R.S. 37:1041-1068, as amended.

Person—an individual, natural person.

Pharmacist—a person holding a certificate of registration issued by the Louisiana Board of Pharmacy pursuant to R.S. 37:1171-1208, as amended.

Physical Therapist—a person holding a license to engage in the practice of physical therapy in the state of Louisiana, pursuant to R.S. 37:2401-2418, as amended.

Podiatrist—a person holding a license to engage in the practice of podiatry in the state of Louisiana, pursuant to R.S. 37:611-628, as amended.

Professional Corporation—any professional corporation a health care provider is authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950, as amended.

Psychologist—a person holding a license to engage in the practice of psychology in the state of Louisiana, pursuant to R.S. 37:2351-2366, as amended.

Registered Nurse—a person holding a license to engage in the practice of nursing in the state of Louisiana, pursuant to R.S. 37:911-931, as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 29:344 (March 2003).

§113. Severability

A. If any provision of these rules, or the application or enforcement thereof, is held invalid, such invalidity shall not affect other provisions or applications of these rules which can be given effect without the invalid provisions or applications, and to this end the several provisions of these rules are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992).

Chapter 3. Organization, Functions, and Delegations of Authority

§301. Board Organization

A. Before taking office, each member of the board duly appointed by the governor shall subscribe before a notary public, and cause to be filed with the secretary of the board, an oath in substantially the following form:

I HEREBY SOLEMNLY SWEAR AND AFFIRM that I accept the trust imposed on me as a member of the Patients' Compensation Fund Oversight Board, and will perform the

duties imposed on me as such by the laws of the state of Louisiana to the best of my ability and without partiality or favoritism to any constituency, group or interests which I may individually represent or with whom I may personally be associated.

B. The board shall annually, at its first meeting following the first day of July of each year, elect from among its members as a chairman, a vice-chairman, and a secretary, each of whom shall serve in such office until their successors are duly elected. The board may elect a successor chairman or secretary at any time that the incumbent of such office resigns from such office or by death or disability becomes incapacitated from discharging the responsibilities of such office.

C. Meetings of the board shall be noticed, convened, and held not less frequently than quarterly during each calendar year and otherwise at the call of the chairman or on the written petition for a meeting signed by not less than that number of board members constituting a quorum of the board. Meetings of the board shall be held on such date and at such time and place as may be designated by the chairman, or in default of designation by the chairman, by agreement of a quorum of the board.

D. Five members of the board shall constitute a quorum for all purposes, including the call and conduct of meetings, the rulemaking functions of the board, and the exercise of all other powers and authorities conferred on the board by law. No member of the board may be represented by proxy at any meeting of the board or otherwise vote or act on or participate in the affairs of the board by proxy. Except as may be otherwise provided by law or by the policies of the board, all actions which the board is empowered by law to take shall be effected by vote of not less than a majority of the members of the board present at a meeting of the board at which a quorum is present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:169 (February 1992).

§303. Executive Director of the Patients' Compensation Fund Oversight Board

A. The position of executive director of the Louisiana Patients' Compensation Fund Oversight Board is hereby established by the board as an unclassified position. The executive director shall be employed by the board and, subject to other provisions of law respecting qualification for and maintenance of governmental employment, hold such office at the pleasure of the board. In addition to other qualifications required by law for such office, the executive director shall be at least 21 years of age, a graduate of an accredited post-secondary college or university, and have had prior professional experience in insurance underwriting and actuarial science as appropriate to the executive director's responsibilities pursuant to these rules.

B. The executive director shall be responsible, and accountable to the board for the overall administration,

operation, conservation, management, and defense of the fund to the extent of the responsibilities imposed on the board by the Act. Without limitation on the scope of such responsibility, the executive director shall be specifically responsible for:

1. receiving and processing health care provider applications for enrollment with the fund;
2. determining whether applicants for enrollment satisfy the standards of financial responsibility and possess the other qualifications for enrollment specified by these rules;
3. timely collection of surcharges from, or paid by insurers on behalf of, enrolled health care providers;
4. certification of enrollment upon the presentation of claims against health care providers enrolled with the fund;
5. processing claims against enrolled health care providers and the fund in accordance with the Act and these rules;
6. collection, accumulation, and maintenance of comprehensive historical claims experience data from enrolled health care providers and insurance companies providing professional liability coverage to health care providers in the state of Louisiana, in such form and array as may be necessary or appropriate to permit the fund's actuary to develop sound and appropriate surcharge rates for the fund;
7. maintenance of accurate, current, and complete data on pending and concluded and closed claims against the fund;
8. coordination of the defense and disposition of claims against the fund;
9. payment of judgments, settlements, arbitration awards, and medical expenses;
10. retention of an actuary for the fund in accordance with §701;
11. development and submission, in conjunction with the PCF's actuary, of surcharge rate and rate change filings with the Louisiana Insurance Rating Board, based on annual actuarial studies;
12. financial accounting for the fund in accordance with generally accepted accounting principles;
13. development and submission of an annual budget and appropriation request as provided by §§1305-1307 of these rules;
14. preparation and submission of such reports on the status, administration, and operation of the fund, and on the disposition of individual claims against the fund, as required by law or as directed by the board; and
15. the discharge and performance of such other duties, responsibilities, functions, and activities as are expressly or impliedly imposed on the board by the Act or as specified by these rules.

C. All authority for the administration and operation of the fund vested in the board by the Act is hereby delegated to the executive director. In the exercise of such authority, the executive director shall be accountable to, and subject to the superseding authority of, the board.

D. Without limitation on the generality of the provision made by §307 for the payment of the expenses of administration and defense of the fund, the salary and employment benefits of the executive director and any expenses properly and lawfully incurred by the executive director in the performance of his duties under these rules shall be payable by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:169 (February 1992), amended LR 29:344 (March 2003).

§305. Fund Property

A. The board is the custodian of all tangible and intangible property, assets, rights, and interests of the fund and the repository for all of the fund's records, files, information, and data. All furniture, fixtures, equipment, goods, supplies, files, records, information, data, computers, computer systems, software, and documentations, and any other tangible or intangible property, rights, or interests of whatsoever kind or nature purchased or acquired by, transferred or donated to, or developed or produced through the use of funds of the PCF, wheresoever or howsoever located or stored, shall be and remain the property of the fund. No property, rights, or interests of the fund shall be sold, transferred, assigned, or alienated by the fund except for compensation to the fund equal to or exceeding the reasonably estimated market value of any such property, rights, or interests and pursuant to the authorization of the executive director.

B. The board shall annually conduct and record an inventory of all of the property, assets, rights, and interests of the fund and shall at all times maintain a current, accurate, and complete schedule of the property, assets, rights, and interests of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§307. Expenses of Administration and Defense

A. All expenses incurred for, by, or on behalf of the executive director or the board in their administration, operation, and defense of the fund, pursuant to the Act and these rules, shall be borne by the fund, subject to the provision of these rules governing budgeting, accounting, and appropriation requests.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

Chapter 5. Enrollment with the Fund

§501. Scope of Chapter

A. The rules of Chapter 5 provide for and govern the qualifications, conditions, and procedures requisite to enrollment with the fund, demonstration and maintenance of financial responsibility, and termination or cancellation of enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§503. Basic Qualifications for Enrollment

A. To be eligible for enrollment with the fund, a person, professional corporation, professional partnership, or institution shall:

1. be a health care provider, as defined by the Act or by these rules, who or which is engaged in the provision of health care services within the state of Louisiana, and which is not organized solely or primarily for the purpose of qualifying for enrollment with the fund;

2. demonstrate and maintain, to the satisfaction of and in the manner specified by the executive director and in accordance with the standards prescribed by §§503-511 hereof, or as otherwise provided by law, financial responsibility for, and with respect to, malpractice or professional liability claims asserted against the person or institution;

3. make application for enrollment upon forms prescribed and supplied by the executive director, pursuant to §513 of these rules; and

4. pay the applicable surcharges to the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§505. Financial Responsibility: Insurance

A. A health care provider shall be deemed to have demonstrated the financial responsibility requisite to enrollment with the fund by submitting certification that the health care provider is or will be insured on a specific date under a policy of insurance, insuring the health care provider against professional health care malpractice liability claims with indemnity limits of not less than \$100,000, plus interest per claim, aggregate annual indemnity limits of not less than \$300,000 plus interest for all claims arising or asserted within a 12-month policy period.

B. To be acceptable as evidence of financial responsibility pursuant to §505, an insurance policy:

1. must be issued:

- a. by an insurance company admitted to do business in this state; or

- b. by an unauthorized insurer which is on the list of approved unauthorized insurers maintained by the Commissioner of Insurance pursuant to R.S. 22:1262.1 and which has:

- i. a rating by A.M. Best and Co. of "A-" or higher; or

- ii. a rating by Standard and Poor's of "AA-" or higher; or

- iii. a rating by Moody's of "Aa" or higher; or

- c. by a risk retention group organized and operating in this state pursuant to the Federal Liability Risk Retention Act of 1986, 15 U.S.C. 3901 et seq., and which has given notice of its operation within this state to the Commissioner of Insurance and is otherwise in compliance with the Louisiana Risk Retention Group Law, R.S. 22:2071 et seq.; or

- d. by the Louisiana Residual Malpractice Insurance Authority, R.S. 40:1299.46;

2. shall be of a form approved by the Commissioner of Insurance of the state of Louisiana and specifically approved by the executive director;

3. must provide for the insurer's assumption of the defense of any covered claim, without limitation on the insurer's maximum obligation respecting the cost of defense;

4. shall be nonassessable;

5. shall not be subject to a retention or deductible payable by the insured health care provider, with respect to liability, costs of defense or claim adjustment expenses, in excess of \$25,000, provided that an insurance policy provision which requires reimbursement of the insurer by the insured of indemnification and/or expenses and which provides that the insurer remains directly and primarily responsible to the patient for the amount thereof shall not be considered a retention and shall, in that regard, be deemed to satisfy the financial responsibility requirements of §505; and

6. must, by provision or endorsement, obligate the insurer to give immediate notice to the executive director of cancellation, termination, or lapse of the policy, or of modification of the scope or limits of its coverage by endorsement or otherwise.

C. The certification required by §505.A shall be issued and executed by an officer or authorized agent of the applicant health care provider's insurer and shall specifically identify the policyholder, the named insureds under such policy, the policy period, the limits of coverage and any applicable deductible or uninsured retention. Such certification shall be accompanied by a complete specimen copy of the applicable policy, or identification of the specific policy form if such form has previously been filed with and approved by the executive director.

D. Upon request, the executive director shall advise applicants as to whether any specified policy form has been

approved pursuant to §505, or provide a list of all policy forms so approved.

E. The insurance coverage required by this rule to demonstrate the requisite financial responsibility for qualification with the fund shall be deemed to be continuing without a lapse in coverage by the fund, provided that the health care provider meets the premium payment conditions of the underlying coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992), amended LR 21:394 (April 1995), LR 23:68 (January 1997), LR 24:333 (February 1998), LR 30:1017 (May 2004).

§507. Financial Responsibility: Self-Insurance

A. A health care provider shall be deemed to have demonstrated the financial responsibility requisite to enrollment with the fund by depositing with the board \$125,000, in money or represented by irrevocable letters of credit, federally insured certificates of deposit, or in bonds, securities cash values of insurance, or other securities approved by the executive director of the principal value of not less than \$125,000. All money, certificates of deposit, bonds or securities deposited pursuant to §507 shall be conditioned only for, dedicated exclusively to, and held in trust for the benefit and protection of and as security for the prompt payment of all malpractice claims arising or asserted against the health care provider.

B. For purposes of §507, upon approval by the board of an application filed by the group, any group of health care providers organized to and actually practicing together or otherwise related by ownership, whether as a corporation, partnership, limited liability partnership or limited liability company, shall be deemed a single health care provider and shall not be required to post more than one deposit. Proof of such status may include a notarized copy of the articles of incorporation, partnership agreement, articles of organization, joint or consolidated entity tax returns, or other documents demonstrating the ownership relation among or between the members of the group, or other evidence which indicates that the members of the group actually practice together for the purpose of health care delivery.

1. This proof of group status shall be submitted to the board:

- a. with the group's original application;
- b. within 30 days of any change in the group's status, organization, or membership; and
- c. within 10 calendar days of receipt of a written demand therefor from the board.

2. It shall be insufficient for qualification under this rule if a group is organized solely or primarily for the purpose of qualifying for enrollment with the fund.

C.1 The following bonds and securities shall be deemed approved by the board for purposes of the deposit required by §507:

a. bonds or securities not in default as to principal or interest which are the direct obligations of, or which are secured or guaranteed as to principal and interest by full faith and credit of the United States, any state or territory of the United States, or the District of Columbia;

b. government sponsored AAA rated securities which carry an implied guarantee from the United States Government;

c. bonds or evidence of indebtedness not in default as to principal or interest which are the direct obligations of, or which are secured or guaranteed as to principal and interest by the issuing body, the state, or political subdivision of this state, or any other state or territory of the United States or the District of Columbia;

d. the bond of an authorized surety company engaged in business in the state of Louisiana which has an A.M. Best rating of A+ VIII or better. In addition, the company should meet the stated minimum rating criteria for two of the following rating services:

- i. Standard and Poor AA;
- ii. Duff and Phelps AA;
- iii. Moody's Aa2;

e. an unconditional letter of credit with an automatic renewal provision where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor;

f. an escrow account in the name of Patients' Compensation Fund where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor.

2. In addition to the above, a health care provider may apply to the board for approval of any other security which, if approved by the board, shall constitute proof of financial responsibility.

3. In addition to depositing the money or original instrument evidencing the approved security with the board, a self-insured health care provider shall be required to execute a pledge agreement prescribed and supplied by the executive director and to provide evidence that written notice, stating that the approved security will be pledged to the board pursuant to the terms of the pledge agreement, has been given to the issuing body.

D. Money, accounts, certificates of deposit, or other approved insurance or securities deposited, pledged or assigned to the board pursuant to §507 shall not be assigned, transferred, sold, mortgaged, pledged, hypothecated or otherwise encumbered by the health care provider nor shall any such deposit, account, or certificate of deposit be subject to writ of attachment, sequestration, or execution except pursuant to a final judgment or court-approved settlement

issued or made in connection with and arising out of a malpractice claim against the health care provider.

E. To maintain financial responsibility for continuing enrollment or qualification with the fund, a health care provider shall at all times maintain the unimpaired principal value of the deposit provided for by §507 at not less than \$125,000. The value of the health care provider's deposit shall be deemed impaired when any portion is seized pursuant to judicial process.

F.1. Reserves for claims against a self-insured health care provider shall, for the purposes of §507, be established in any of the following ways:

a. the self-insured health care provider shall, within 90 days of notice of a claim and no less than every 90 days thereafter, submit a proposed reserve amount to the executive director, along with appropriate supporting documentation. Unless rejected by the executive director within 30 days of receipt, the reserve amount submitted shall be deemed approved. If a reserve amount is rejected timely, the self-insured health care provider may, within 15 days, submit a new reserve amount or appeal the rejection of the executive director. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may accept the proposed reserve, establish a new amount, or defer action for further information. The decision of the board shall be final;

b. the self-insured health care provider may contract with a consultant company approved by the board to set its reserves;

c. the self-insured health care provider may set its reserves with the assistance of in-house counsel and/or risk managers and/or defense attorneys when approved to do so by the board.

2. In granting approval under either §507.F.b or c, the board shall give consideration to the qualifications of the consultant company, in-house counsel, risk managers and/or defense attorneys including, but not limited to, experience in reserve setting and history of approval by national excess insurance companies. Under §507.F.b and c, the self-insured health care provider shall submit quarterly loss-run reports to the fund, and the fund may make annual on-site inspections of the files and reserves.

G. A self-insured health care provider who evidences financial responsibility pursuant to §507 may, upon 45 days prior written notice to the executive director, withdraw any portion of the deposit prescribed by §507 provided that, following such withdrawal, the value of the deposit shall not be impaired.

H.1. A self-insured health care provider who has evidenced financial responsibility pursuant to §507 may withdraw the deposit prescribed by §507 upon authorization of the executive director. The security furnished as proof of financial responsibility, or a substitution which has been approved by the board, shall remain on deposit and pledged to the board during the term of the health care provider's

enrollment as a self-insured health care provider with the fund and for the longer of a three-year period following termination of such enrollment or as long as any medical malpractice claim is pending, whether with the board or in a court of competent jurisdiction. After this time period, authorization may be given when the health care provider files with the executive director, not less than 30 days prior to the date such withdrawal is to be effected, a certificate, signed and verified under oath by the health care provider, certifying:

a. the date the health care provider terminated enrollment with the fund as a self-insured health care provider;

b. that there are no medical malpractice claims pending with the board or in a court of competent jurisdiction;

c. that there are no unpaid final judgments or settlements against or made by the health care provider in connection with or arising out of a malpractice claim; and

d. that there are no unasserted medical malpractice claims which are probable of assertion against the health care provider.

2. Effective as of the date on which a self-insured health care provider's deposit is withdrawn pursuant to §507, the health care provider's enrollment and qualification with the fund shall be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:171 (February 1992), amended LR 18:737 (July 1992), LR 23:68 (January 1997), LR 29:344 (March 2003).

§509. Financial Responsibility: Self-Insurance Trusts

A. The shareholders of a professional corporation, the partners of a professional partnership, a solo practitioner, a health care provider institution, or a group of such institutions may demonstrate the financial responsibility requisite to enrollment with the fund by the establishment and maintenance of a financially and actuarially sound self-insurance trust, approved by the executive director, and making and maintaining, on behalf of such trust as an entity, a deposit of not less than \$125,000 in money or represented by irrevocable letters of credit, federally-insured certificates of deposit, or in bonds or securities approved by the executive director, of the principal value of not less than \$125,000.

B.1. The following bonds and securities shall be deemed approved by the board for purposes of the deposit required by §509:

a. bonds or securities not in default as to principal or interest which are the direct obligations of, or which are secured or guaranteed as to principal and interest by full faith and credit of the United States, any state or territory of the United States, or the District of Columbia;

b. government sponsored AAA rated securities which carry an implied guarantee from the United States Government;

c. bonds or evidence of indebtedness not in default as to principal or interest which are the direct obligations of, or which are secured or guaranteed as to principal and interest by the issuing body, the state, or political subdivision of this state, or any other state or territory of the United States or the District of Columbia;

d. the bond of an authorized surety company engaged in business in the state of Louisiana which has an A.M. Best rating of A+ VIII or better. In addition, the company should meet the stated minimum rating criteria for two of the following rating services:

- i. Standard and Poor AA;
- ii. Duff and Phelps AA;
- iii. Moody's Aa2;

e. an unconditional letter of credit with an automatic renewal provision where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor;

f. an escrow account in the name of Patients' Compensation Fund where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor.

2. In addition to the above, a health care provider may apply to the board for approval of any other security which, if approved by the board, shall constitute proof of financial responsibility.

3. In addition to depositing the money or original instrument evidencing the approved security with the board, a self-insured trust shall be required to execute a pledge agreement prescribed and supplied by the executive director and to provide evidence that written notice, stating that the approved security will be pledged to the board pursuant to the terms of the pledge agreement, has been given to the issuing body.

C. Application to the executive director for approval of a self-insurance trust as evidence of financial responsibility shall include:

1. identification of, by name, address, and category of practitioner or each shareholder of an applicant professional corporation, each partner of an applicant professional partnership or each health care institution participating in the self-insurance trust;

2. a certified copy of the self-insurance trust instrument and any related organizational or operational documents;

D. The executive director shall approve of a self-insurance trust if such trust meets the requirements of the Health Care Financing Administration's (HCFA) *Medicare Provider Reimbursement Manual*, Part 1, §2162.7, related to self-insurance trusts. Those standards shall not, however, be

exclusive and the executive director may approve such other qualified self-insurance trusts as appropriate, although they do not meet those requirements.

E. Each self-insurance trust approved by the executive director as evidence of financial responsibility pursuant to §509 shall be subject to audit or examination upon reasonable prior notice to the trustees thereof, and each such trust shall, within 60 days of the conclusion of its fiscal year, file with the executive director financial statements setting forth the financial condition of the trust at the last day of the preceding year and for the year then ended, audited or reviewed by an independent certified public accountant.

F. Each self-insurance trust approved by the executive director as evidence of financial responsibility pursuant to §509 shall give written notice to the executive director within 10 days of any date that:

1. the trust instrument or other organizational or operational documents are amended; or

2. any participating member of the trust ceases to be a member or any new member begins participation with the trust.

G. For the purpose of determining whether the deposit required of an approved self-insurance trust is impaired, the unpaid final judgments, court-approved settlements, and reserves against claims against all members of a self-insurance trust shall be aggregated.

H.1. Reserves for claims against a self-insurance trust shall, for the purposes of §509, be established either of the following ways:

a. the self-insurance trust shall, within 90 days of notice of a claim and no less than every 90 days thereafter, submit a proposed reserve amount to the Office of Risk Management, along with appropriate supporting documentation. Unless rejected by the Office of Risk Management and the executive director within 30 days of receipt, the reserve amount submitted shall be deemed approved. If a reserve amount is rejected timely, the self-insured trust may, within 15 days, submit a new reserve amount or appeal the rejection to the board. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may accept the proposed reserve, establish a new amount, or defer action for further information. The decision of the board shall be final;

b. the self-insurance trust may contract with a consultant company approved by the board to set its reserves; or

c. the self-insurance trust may set its reserves with the assistance of in-house counsel and/or risk managers and/or defense attorneys when approved to do so by the board.

2. In granting approval under either §509.H.1.b or c, the board shall give consideration to the qualifications of the consultant company, in-house counsel, risk manager and/or

defense attorneys including, but not limited to, experience in reserve setting and history of approval by national excess insurance companies. Under both §509.H.1.b and c, the self-insured trust shall submit quarterly loss-run reports to the fund, and the fund may make annual on-site inspections of the files and reserves.

I. A self-insurance trust approved by the executive director as evidence of financial responsibility shall be treated the same as insurance, and each health care provider covered by such a self-insurance trust shall be considered to have evidenced financial responsibility as provided in §505.

J. In the event that a self-insurance trust's deposit becomes impaired, the executive director shall give written notice of such impairment to the self-insurance trust, and the self-insurance trust shall, unless a shorter or longer period is provided by the board, have 120 days from receipt of such notice to make such additional deposit pursuant to §509.A as will restore the minimum deposit value prescribed by §509. A self-insurance trust's enrollment with the fund shall terminate on and as of the last day set by these rules or, if applicable, the board, if the health care provider has not on or prior to such date restored the minimum deposit value prescribed by §509.

K. A self-insurance trust which evidences financial responsibility pursuant to §509 may, upon 45 days prior written notice to the executive director, withdraw any portion of the deposit prescribed by §509 provided that following such withdrawal, the value of the deposit shall not be impaired.

L.1. A self-insurance trust which has evidenced financial responsibility pursuant to §509 may withdraw the deposit prescribed by §509 upon authorization of the executive director. The security furnished as proof of financial responsibility, or a substitution which has been approved by the board, shall remain on deposit and pledged to the board during the term of the trust's members' enrollments as self-insured health care providers with the fund and for the longer of a three-year period following termination of such enrollment or as long as any medical malpractice claim is pending against the trust or any of its members, whether with the board or in a court of competent jurisdiction. After this time period, authorization may be given when the trust files with the executive director, not less than 30 days prior to the date such withdrawal is to be effected, a certificate, signed and verified under oath by the trustee of the trust, certifying:

- a. the date that the last remaining member(s) of the trust terminated enrollment with the fund as self-insured health care provider(s);
- b. that there are no medical malpractice claims against the trust or any of its members pending with the board or in a court of competent jurisdiction;
- c. that there are no unpaid final judgments or settlements against or made by the trust or any of its members in connection with or arising out of a malpractice claim; and

d. that there are no unasserted medical malpractice claims which are probable of assertion against the trust or any of its members.

2. Effective as of this date on which a self-insurance trust's deposit is withdrawn pursuant to §509, the member's deposit of the trust enrollment and qualification with the fund shall be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:172 (February 1992), amended LR 18:737 (July 1992), LR 23:69 (January 1997), LR 29:345 (March 2003).

§511. Coverage: Partnerships and Professional Corporations

A. When, and during the period that, each shareholder, partner, member, agent, officer, or employee of a corporation, partnership, limited liability partnership, or limited liability company, who is eligible for qualification as a health care provider under the Act, and who is providing health care on behalf of such corporation, partnership, or limited liability company, is enrolled with the fund as a health care provider, having paid the applicable surcharges due the fund and demonstrated and maintained financial responsibility in accordance with the standards prescribed by §§503-511 for enrollment of such individual, such corporation, partnership, limited liability partnership, or limited liability company shall, without the payment of an additional surcharge, be deemed concurrently qualified and enrolled as a health care provider with the fund when, and during the period that such corporation, partnership, limited liability partnership, or limited liability company demonstrates and maintains financial responsibility in accordance with the standards prescribed by §§503-511.

B. The corporation, partnership, limited liability partnership, or limited liability company shall furnish to the board, concurrently with its enrollment and renewal application, the name(s) of each shareholder, partner, member, agent, officer, or employee who is eligible for qualification and enrollment with the fund as a health care provider and evidence of its financial responsibility in accordance with the standards prescribed by §§503-511.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992), amended LR 29:345 (March 2003), LR 30:1017 (May 2004).

§513. Enrollment Procedure

A. Application for enrollment with the fund shall be made upon forms prescribed and supplied by the executive director. The executive director shall require that each applicant supply his or its proper legal name, the applicant's principal professional address, the address of other professional offices or places of practice of the applicant, the applicant's professional license, certification, or registration number, information relating to the nature and scope of the

applicant's practice sufficient to identify the class or category of the practitioner, information on malpractice claims previously concluded or then pending against the applicant, and such other information as the executive director may prescribe.

B. The application shall be accompanied by evidence of financial responsibility in the form prescribed by §§505-509 of these rules, as applicable.

C. Upon receipt of a completed application, the executive director shall advise the applicant, in writing, of the executive director's determination as to whether the applicant is qualified for enrollment with the fund, and if qualified, of the applicable surcharge payable to the fund. The surcharge shall be paid by the applicant and collected by the fund in accordance with §§711-713 of these rules.

D. When the executive director determines that an applicant is not qualified for enrollment with the fund, he shall notify the applicant by registered or certified mail, return receipt requested, within 30 days of receipt of the completed application. The applicant may, within 15 days of receipt of the notice, appeal the determination to the board by mailing notice of said appeal by registered or certified mail, return receipt requested. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may hear such evidence as it deems appropriate and uphold or reverse the decision of the executive director. The decision of the board shall be final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992).

§515. Certification of Enrollment

A. Upon receipt and approval of a completed application (including evidence of financial responsibility pursuant to §505, §507 or §509) and payment of the applicable surcharge by or on behalf of the applicant health care provider, the executive director shall issue and deliver to the health care provider a certificate of enrollment with the fund, identifying the health care provider and specifying the effective date and term of such enrollment and the scope of the fund's coverage for that health care provider.

B. Duplicate or additional certificates of enrollment shall be made available by the executive director to and upon the request of an enrolled health care provider or his or its attorney, or professional liability insurance underwriter when such certification is required to evidence enrollment or qualification with the fund in connection with an actual or proposed malpractice claim against the health care provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992), amended LR 23:69 (January 1997), LR 29:346 (March 2003), LR 30:1018 (May 2004).

§517. Expiration, Renewal of Enrollment

A. Enrollment with the fund expires:

1. as to a health care provider evidencing financial responsibility by certification of insurance pursuant to §505 of these rules, on and as of:

a. the effective date and time of termination of the policy period of the health care provider's professional liability insurance coverage; or

b. the last day of the applicable period for which the prior annual surcharge applied in the event that the annual surcharge for renewal coverage is not paid by the health care provider to the insurer on or before 30 days following the expiration of the prior enrollment period.

2. as to a health care provider evidencing financial responsibility pursuant to §§507-509 of these rules, at 11:59 p.m., central standard time, at the conclusion of one year from the date on which enrollment became effective.

B. Enrollment with the fund must be annually renewed by each enrolled health care provider on or before termination of the enrollment period by submitting to the executive director an application for renewal, upon forms supplied by the executive director, and payment of the applicable surcharge in accordance with the rules hereof providing for the fund's billing and collection of surcharges from insured and self-insured health care providers. Each insured health care provider shall cause the insurer to submit a certificate of insurance to the executive director along with the application for renewal. Each self-insured health care provider and each health care provider covered by a self-insurance trust shall submit, along with the application for renewal, original documents which indicate that the health care provider's deposit with the board is current and/or not in default.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003), repromulgated LR 29:579 (April 2003).

Chapter 7. Surcharges

§701. PCF Consulting Actuary

A. In accordance with the provisions of law applicable to contracting for personal, professional, or consulting services, the executive director shall retain a qualified, competent, and independent consulting actuary to advise and consult the fund on all aspects of the fund's administration, operation, and defense which require application of the actuarial science and to perform and submit the annual actuarial study required by the Act and these rules predicate to the fund's annual surcharge rate application filings, as specified hereinafter. An individual actuary contracted by the fund, or a principal actuary assigned to the engagement and

employed by a partnership, firm, or corporation contracted by the funds, shall possess formal education and at least a baccalaureate degree in the actuarial sciences, shall be a full member of the Casualty Actuarial Society, and shall have had substantial prior experience in providing services as a consulting actuary to insurance companies underwriting professional health care liability insurance.

B. The fund's contract with a consulting actuary shall provide that the consulting actuary shall be responsible for:

1. advising the executive director with respect to the necessary and proper content and form of claims experience data collected and maintained by the executive director;

2. advising the executive director with respect to the establishment, maintenance, and adjustment of reserves on individual claims against the fund and the establishment, maintenance, and adjustment of reserves for incurred but not reported claims;

3. performing actuarial analysis of claims experience data collected and maintained by the executive director with respect to the fund, commercial professional liability insurers doing business in this state, self-insured health care providers, together, as necessary or appropriate, with regional or national professional health care liability claims experience data, and development, in consideration of the fund's allocated and unallocated expenses, its organization, administration, and legal and regulatory constraints, of a surcharge rate structure, rated and classified according to the several classes or risks against which the fund provides compensation, that shall reasonably ensure that the PCF is sufficiently funded so as to be and remain financially and actuarially capable of providing the compensation for which it is organized;

4. developing, in conjunction with the executive director, surcharge rate applications and requests for surcharge rate changes in accordance with the consulting actuary's actuarial analyses, for submission to and filing with the Louisiana Insurance Rating Commission (LIRC);

5. personal presentation of surcharge rate and rate change applications on behalf of the fund at meetings of the LIRC, with the staff of the LIRC, and with such other interested or affected persons, firm, organizations, and entities as the executive director may request;

6. reviewing, and advising the executive director with respect to the funding and actuarial adequacy of self-insurance trusts and other plans submitted to the executive director by self-insured applicants for enrollment with the fund as evidence of financial responsibility; and

7. generally advising and consulting with the executive director on all actuarial questions affecting the administration, operation, and defense of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003).

§703. Annual Actuarial Study

A. An actuarial study of the fund and the surcharge rate structure necessary and appropriate to ensure that it is and remains financially and actuarially sound shall be performed annually by the PCF's consulting actuary on the basis of an actuarial analysis of all relevant claims experience data collected and maintained by the fund. In conjunction with the executive director, the consulting actuary shall, on behalf of the board, develop and prepare for submission to the Louisiana Insurance Rating Commission (LIRC) an application for surcharge rates or rate changes.

B. In the performance of the fund's annual actuarial study and the development of a financially sound and appropriate surcharge rate structure for the fund, the PCF's consulting actuary and the executive director shall accord the greatest weight to the claims experience of the fund and of commercial professional health care liability insurance underwriters and self-insurance funds with respect to the risk underwritten by such insurers and self-insurance funds in this state and as particularly reflected in such insurers' then most recent premium rate filings with the LIRC or such self-insurance funds' current rate structure and supporting data, provided, however, that such data shall be viewed in light of national claims experience data and provided further that the fund's consulting actuary may place reliance on national claims experience data when, in the opinion of such actuary, claims experience within the state of Louisiana as to any class of risks provides an insufficient basis for reliance thereon for purposes of actuarial analysis or in calculating indicated surcharge rates.

C. Without respect to the rate structure indicated by any annual actuarial study of the fund, no rate application which, if approved and implemented, would or could result in a reduction of the aggregate annual surcharges collected by the fund, shall be filed by the fund when the total amount of the fund is, or by effect of such rate application could become, less than 150 percent of the sum of the aggregate annual surcharges collected by the fund, reserves against individual claims, reserves for incurred but not reported claims, and allocated and unallocated expenses of the fund's administration, operation, and defense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 19:204 (February 1993), LR 24:1111 (June 1998).

§705. Risk Rating

A. Surcharge rates collected by the fund shall be based on and classified according to the classes and categories of health care liability risks underwritten by the fund with respect to each class of health care practitioners and institutions eligible for enrollment with the fund. With regard to hospitals, surcharge rates collected by the fund shall be based on the annual average number of occupied beds. Risk classifications and ratings adopted by the fund shall be based on actuarial analysis of the claims experience

of health care provider groups enrolled with the fund and equivalent data and practices of commercial insurance underwriters and self-insurance funds insuring such groups. Risk rating classifications for health care providers eligible for enrollment with the fund shall be based on Louisiana claims experience data, including the PCF's own claims experience, unless the PCF's actuary affirmatively demonstrates that, as respects any class of provider, reasonably obtainable, competent, and credible Louisiana claims experience data provides an insufficient basis for such classifications under generally accepted insurance actuarial standards, in which case regional or national claims experience data and statistics relative to such classes of health care provider may be utilized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 29:346 (March 2003).

§707. Rate Applications, Filings; Notice of Rates

A. The PCF's application for surcharge rates or rate changes, if indicated by the annual actuarial study conducted pursuant to §703, shall be filed with the LIRC by the executive director on behalf of the board.

B. Within 30 days of the date on which the LIFIC approves surcharges rates or rate changes which may be implemented by the fund, the executive director shall give written notice of such rates or rate changes, as applicable, to each commercial insurance company authorized and admitted to do business in the state as a casualty insurer and then engaged in underwriting the professional liability risks of any class of health care provider eligible for enrollment with the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 24:1112 (June 1998).

§709. Interim, Emergency Rate Filings

A. Interim or emergency applications for surcharge rates or rate changes may be filed by the fund with the LIRC at any time when the executive director, in consultation with the PCF's consulting actuary, determines that a surcharge rate change is necessary to maintain a fund surplus of not less than 50 percent of the sum of the aggregate annual surcharges collected by the fund, reserves against individual claims, reserves for incurred but not reported claims, and allocated and unallocated expenses of the fund's administration, operation, and defense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992).

§711. Payment of Surcharges: Insurers

A. Applicable surcharges for enrollment and qualification with the fund shall be collected on behalf of the fund by commercial professional health care liability insurance companies and approved self-insurance trust funds from insured health care providers electing to enroll and qualify with the fund. Such surcharges shall be collected by such insurers and funds at the same time and on the same basis as such insurers' and fund's collection of premiums or contributions from such insureds. Surcharges collected by such insurers and funds on behalf of the fund shall be due and payable and remitted to the fund by such insurers and funds within 45 days from the date on which such surcharges are collected from any insured health care provider.

B. Annual surcharges for renewal coverage due the fund by insured health care providers whose surcharges are collected by insurers and funds for enrollment and qualification with the fund shall be due and payable to the collecting insurers and funds on or before 30 days following the expiration of the prior enrollment period. Remittance of surcharges to the fund by the insurers and funds shall be made in such form and accompanied by records in such forms or on such forms as may be prescribed by the executive director so as to provide for proper accounting of remitted surcharges and the identity and class of health care providers on whose behalf such surcharges are remitted. Such insurers and funds remitting surcharges to the fund shall certify to the fund, at the time of remitting such surcharge to the fund, the date that the surcharges were collected by them from the health care providers. The payment of surcharges by an approved self-insurance trust that does not collect premiums or contributions from insureds will be governed by §713 hereof.

C. Failure of the commercial professional health care liability insurers, commercial insurance underwriters, and approved self-insurance trust funds to remit payment within 45 days of collecting such annual surcharge shall subject the commercial professional liability insurers, commercial insurance underwriters, and approved self-insurance trust funds to a penalty of 12 percent of the annual surcharge and all reasonable attorney's fees. Upon the failure of the commercial professional health care liability insurers, commercial insurance underwriters and approved self-insurance trust funds to remit as provided in §711, the board may institute legal proceedings to collect the surcharge, together with penalties, legal interest, and attorney's fees.

D. If the instrument used to pay the surcharge is returned to the fund by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be notified thereof by the fund. If the surcharge is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the fund within 10 calendar days of the provider's receipt of said notice, then the provider's coverage with the fund shall be terminated as of the end of the previous enrollment period.

E. It is the purpose of §711 that insurers and approved self-insurance trust funds remit surcharges collected from

their insured providers to the fund timely. The timeliness of surcharge remittances to the fund by insurers and approved self-insurance trust funds shall not affect the effective date of fund coverage. However, the failure of insured health care providers to timely remit applicable surcharges to insurers and approved self-insurance trust funds for renewal may result in lapses of coverage with the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 20:432 (April 1994), LR 23:69 (January 1997), LR 29:346 (March 2003).

§713. Payment of Surcharges: Self-Insureds

A. Not less than 60 days prior to the termination of enrollment of a health care provider, the executive director shall cause each self-insured health care provider enrolled with the fund and each self-insured health care provider having been approved for enrollment with the fund, to receive a statement of surcharges due the fund by the health care provider for enrollment with the fund during the succeeding enrollment year.

B. Surcharges due the fund by self-insured health care providers for enrollment with the fund for an enrollment year shall be due and payable to the fund prior to the effective date of the coverage, or renewal of coverage, to which the surcharge applies. Remittance of surcharges to the fund shall be made in such form and accompanied by records in such form or on such forms as may be prescribed by the executive director so as to provide for proper accounting of remitted surcharges and the identity and class of health care provider remitting surcharges.

C. If the instrument used to pay the surcharge is returned to the fund by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be notified thereof by the fund. If the surcharge is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the fund within 10 calendar days of the provider's receipt of said notice, then the provider's coverage with the fund shall be terminated as of the end of the previous enrollment period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 20:432 (April 1994), LR 23:69 (January 1997).

§715. Amount of Surcharges; Form of Coverage; Conversions

A. A health care provider qualified for enrollment by evidence of liability insurance pursuant to §505, or by evidence of participation in an approved self-insurance trust pursuant to §509, shall pay the fund surcharge amount in the most recently approved rate filing which is applicable to his provider type, years enrolled in the fund, and which most closely corresponds to the class and form of coverage of said primary liability insurance or self-insurance trust. The form

of coverage provided by the fund shall be identical to that provided by the qualifying policy of insurance or self-insurance except where the policy conflicts with applicable law or regulation.

B. A health care provider qualified for enrollment by evidence of self-insurance pursuant to §507 shall pay the fund surcharge amount in the most recently approved rate filing which is applicable to self-insured coverage and to his provider type. The form of coverage provided by the fund shall be self-insured coverage as defined in §109.A of these rules.

C.1. When a health care provider who had previously purchased claims-made coverage from the fund elects to purchase occurrence coverage from or discontinue enrollment in the fund, he shall not have coverage afforded by the fund for any claims arising from acts or omissions occurring during the fund's claims-made coverage but asserted after the termination of the claims-made coverage unless he evidences financial responsibility for those claims either by purchasing an extended reporting endorsement or posting a deposit with the board pursuant to §507 and pays, on or before 45 days following the termination of the claims-made coverage, the surcharge applicable to fund tail coverage for the corresponding claims-made period(s).

2. When a health care provider who had previously purchased claims-made coverage from the fund elects to purchase self-insured coverage from the fund, he shall not have coverage afforded for any claims arising from acts or omissions occurring during the fund's claims-made coverage but asserted after the termination of the claims-made coverage, unless he evidences financial responsibility for those claims either by purchasing an extended reporting endorsement or posting a second deposit with the board pursuant to §507 and pays, on or before 45 days following the termination of the claims-made coverage, the surcharge applicable to fund tail coverage for the corresponding claims-made period(s).

3. In special circumstances, the board may, at its discretion, waive the payment of an additional surcharge and allow tail coverage to a provider without the payment of the applicable-surcharge. Each such case requires an individual written request for relief to the board, and will be decided on individual circumstances. The board's criteria for such decisions shall include, but not be limited to:

- a. the reason for such request;
- b. the length and basis of the provider's enrollment with the fund;
- c. the potential claims liability to the fund;
- d. the provider's intention to cease or continue to practice in Louisiana; and
- e. the potential effects if the fund refuses to allow such relief.

D. When a health care provider who had previously purchased claims-made coverage from the fund permanently

retires after 10 consecutive years of enrollment, or when an institutional provider and any successors who had previously purchased claims-made coverage from the fund permanently ceases to do business and/or practice medicine after 10 consecutive years of coverage, or when a health care provider who had previously purchased claims-made from the fund dies or becomes permanently disabled, then the surcharge to the fund for tail coverage for claims occurring during the existence of the fund claims-made coverage shall be considered to have been paid. However, continuous coverage through the fund under this rule shall only apply if the affected provider or institution maintains continuous financial responsibility either through insurance coverage or submission of the security required for self-insurance under §507, including tail coverage, for the primary \$100,000 for each claim. Further, this rule shall only apply to the successor of an institutional provider to the extent that the predecessor business entity was enrolled, and only to the single business entity which had been previously enrolled. This rule shall not apply to other business entities of the successor provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 23:69 (January 1997), amended LR 29:347 (March 2003), LR 30:1018 (May 2004).

Chapter 9. Scope of Coverage

§901. Effective Date

A. A health care provider who qualifies for enrollment with the fund by demonstrating financial responsibility through professional liability insurance pursuant to §505 of these rules, shall be deemed to become and be enrolled with the fund effective as of the date on which the surcharge payable by or on behalf of such health care provider is timely collected in accordance with §711 hereof and the applicable policies and procedures of the insurer for premium payments. If such surcharge is not timely collected, the effective date of enrollment with the fund shall be the date on which such surcharge is paid to the fund is collected or accepted by the insurer.

B. A health care provider who qualifies for enrollment with the fund by demonstrating financial responsibility by self-insurance pursuant to §507 or by participation in an approved self-insurance trust pursuant to §509 of these rules, and by payment in full of the surcharges due the fund, shall be deemed to become and be enrolled with the fund effective as of the date following the date on which a then-enrolled provider's prior term of enrollment terminates, or the date on which the provider pays the surcharges due the fund, being then qualified and eligible for enrollment with the fund, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR

18:176 (February 1992), amended LR 23:70 (January 1997), LR 29:347 (March 2003).

§903. Term of Enrollment

A. The enrollment of a health care provider qualified for enrollment by evidence of liability insurance pursuant to §505 hereof shall expire on and as of the date on which the policy period of the insurance policy evidencing such financial responsibility expires.

B. The enrollment of a health care provider qualified for enrollment by evidence of self-insurance pursuant to §507 hereof shall expire one year from the date on which such health care provider's enrollment became effective.

C. The enrollment of a health care provider qualified for enrollment by evidence of participation in approved self-insurance trust pursuant to §509 of these rules shall expire on and as of the earlier of the date on which the health care provider ceases to be a participating member of such trust or one year from the date on which such health care provider's enrollment became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

§905. Scope of Coverage: Insureds

A. With respect to health care providers qualified from enrollment with the fund by evidence of liability insurance pursuant to §505 hereof, the fund shall be liable for compensation for claims asserted against the health care provider only within the scope of coverage afforded by, and subject to the limitations and exclusions of, the policy of professional liability insurance evidencing the health care provider's financial responsibility, subject to the limitation of liability prescribed by the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

§907. Scope of Coverage: Self-Insureds

A. With respect to health care providers qualified to enroll with the fund by evidence of self-insurance pursuant to §507 hereof, or by evidence of participation in an approved self-insurance trust pursuant to §509, the fund shall be obligated to pay compensation to the extent provided by the Act only with respect to claims arising from an incident which occurred during the effective period of enrollment, regardless of whether the provider was actively enrolled on the date on which the claim was reported, so long as the provider continues to meet the financial responsibility requirements of R.S. 40:1299.42 for continued qualification.

B. The fund's obligation for compensation shall extend to the vicarious liability of an enrolled health care provider for acts or omissions of any employee or agent of the provider when acting within the course and scope of his or

her employment, except any physician, physician's assistant, certified registered nurse anesthetist, or primary nurse associate (nurse practitioner) employed by the health provider when such employed person is not enrolled with the fund. However, in the case of hospitals, the fund's obligation for compensation shall extend to the vicarious liability of the hospital for the acts or omissions of any employee or agent, other than a physician, when acting within the course and scope of his or her employment. The fund's obligation for compensation does not and shall not extend to any liability or obligation of a health care provider, which the health care provider has assumed or undertaken by contract or agreement, to indemnify, defend or hold harmless any other person, firm or corporation.

AUTHORITY NOTE: Promulgated in accordance with R~S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 23:70 (January 1997).

§909. Scope of Coverage: Self-Insurance Trusts

A. With respect to health care providers qualified for enrollment with the fund by evidence of participation in an approved self-insurance trust pursuant to §509 hereof, the fund shall be liable for compensation for claims asserted against the health care provider only within the scope of coverage afforded by, and subject to the limitations and exclusions of, the self-insurance trust instrument evidencing the health care provider's financial responsibility, subject to the limitation of liability prescribed by the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

Chapter 11. Reporting

§1101. Reporting of Claims, Reserves, Proposed Settlement

A. Within 30 days of the date on which a malpractice claim is asserted, or of the date on which a claim becomes probable of assertion, against an enrolled health care provider, the health care provider, or the health care provider's liability insurer, shall give notice of such claim to the executive director, if the executive director has not previously received notice of the claim. Such notice shall include identification of the person or persons asserting the claim, the nature of the claim, the circumstances surrounding and the date or dates of the occurrences giving rise to the claim. Such notice shall also advise of the name and address of the attorney at law, if any, retained by the health care provider or his or its insurer to represent the health care provider in defense of the claim. If an attorney has not been retained by the health care provider or insurer at the time of such notice, notice shall thereafter be given to the executive director within 10 days of the retention of an attorney to represent the health care provider.

B. Upon the assertion of a claim against an insured health care provider enrolled with the fund or against a self-insured health care provider which establishes reserves against individual claims, the health care provider or his or its insurer, as the case may be, shall promptly give notice to the executive director of the amount of indemnity, defense cost, and other loss adjustment expense reserves as have been established and allocated to the claim by the health care provider or insurer. Within 10 days of the adjustment or modification of any such reserve, a health care provider or insurer shall give notice of such adjustment or modification to the executive director.

C. Each health care provider enrolled with the fund, or the insurer of an enrolled health care provider on behalf of such health care provider, shall give not less than 10 days prior written notice to the executive director of any proposed compromise or settlement of a malpractice claim asserted against the health care provider.

D. Within 20 days of the receipt of a malpractice claim against an enrolled health care provider in the form of a lawsuit, the health care provider, or the health care provider's liability insurer, shall furnish a copy of the lawsuit to the PCF. The health care provider, or the health care provider's liability insurer, shall also furnish to the PCF within 20 days of receipt, a copy of all amending pleadings related to the lawsuit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 29:348 (March 2003).

§1103. Claims Experience Reporting: Insurers, Institutions and Self-Insured

A. On or before March 1 of each year, each insurance company, approved risk retention group, and approved self-insurance trust fund then providing professional health care liability insurance to any health care providers enrolled with the fund, and each enrolled self-insured health care provider shall file with the fund, through the executive director, a summary of the health care liability claims experience of such health care provider or insurer fully developed for each of the most recently concluded 10 calendar years or for such fewer years as the health care provider or insurer has engaged in business in the state. Claims experience data filed by insurance companies shall include data for all health care providers insured by such insurer in the state, whether enrolled with the fund or not.

B. The reports required by this rule shall contain such information and data and shall be made and filed upon and in accordance with such forms, instructions, and array as may be specified and supplied by the executive director, all of which shall be distributed to those required to report no later than the preceding December 1. Such reports shall be signed by an officer of the insurance company or institution and shall be certified by an independent certified public accountant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1105. Noncompliance; Failure to Report

A. Noncompliance with the reporting and filing requirements prescribed by these rules shall be deemed adequate and sufficient legal grounds for the cancellation and termination of enrollment of any enrollee of the fund insured by an insurance company failing or refusing to so report.

B. Noncompliance with the reporting and filing requirements prescribed by these rules shall be deemed adequate and sufficient legal grounds for the cancellation and termination of the enrollment of any self-insured health care provider, approved risk retention group of self-insurance trust failing or refusing to report as required by these rules. The executive director shall give written notice to any self-insured health care provider which, being required to file reports under these rules, fails to do so within the time specified. The enrollment of a health care provider who does not file required reports in proper form shall be terminated 30 days following the mailing of such notice by the executive director if the health care provider has not before such date filed the required reports in proper form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1107. Confidentiality

A. All reports, notices, communications, information, records, and data made or given to the executive director or Office of Risk Management pursuant to the provisions of Chapter 11 shall be deemed privileged and confidential by and in the possession of the executive director and Office of Risk Management and their agents and contractors, and unless ordered by a court of competent jurisdiction after a contradictory hearing, shall not be disclosed to any third party pursuant to request, subpoena, or otherwise without the express written authorization and consent of the person, office, or entity making or giving, or originally possessing any such reports, notices, communications, information, records, or data. This rule shall not, however, prohibit disclosure or publication after prior consent of the board of aggregated information or data from which information or data relative to individual health care providers may not be discerned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

Chapter 13. Fund Data Collection, Maintenance; Accounting and Reporting

§1301. Fund Data Collection, Maintenance

A. All information and data collected by or reported to the fund relating to the administration, operation, or defense of the fund shall be recorded and maintained by the board. All of such information and data shall, to the extent reasonably possible, be electronically computer database stored and maintained so as to be readily and efficiently accessible for utilization in the processing of applications for enrollment, in establishment and adjustment of claim reserves and reserves for incurred but not reported claims, in the preparation and analysis of claims experience data in connection with the development of surcharge rate filings, and in the defense of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1303. Fund Accounting

A. The executive director shall be responsible for maintaining accounts and records for the fund as may be necessary and appropriate to accurately reflect the financial condition of the fund on a continuing basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1305. Annual Budget

A. The executive director shall annually, on or before December 1, project revenue and expense budgets for the fund for the succeeding fiscal year in accordance with the provisions of R.S. 39:21-38. Such budget shall reflect all revenues projected to be collected or received by or accruing to the fund during such fiscal year, together with the projected expenses of the administration, operation, and defense of the fund and satisfaction of its liabilities and obligations. Such budgets shall be submitted to the board for its approval, and as approved by the board, submitted on or before the following January 5 to the governor, the joint legislative committee on the budget, and the legislative fiscal office, in accordance with R.S. 39:33.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1307. Appropriation Request

A. The executive director shall, on or before December 1 of each year, prepare an appropriation request, based on the annual budget prepared pursuant to §1305 of these rules, for approval by the board. The appropriation request on behalf

of the fund, in accordance with R.S. 40:1299.44, shall be transmitted to the governor by the board on or before December 31 of each year for the succeeding fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992).

§1309. Periodic Reports

A. The executive director shall prepare or cause to be prepared, within 30 days of the conclusion of each calendar quarter, statements of the financial condition of the fund at the end of such calendar quarter and for the period then ended. Such statement may be prepared, at the election of the executive director, in accordance with the statutory accounting principles applicable to liability insurance companies authorized to do business in this state or in accordance with generally accepted accounting principles relating to accounting for governmental funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992).

§1311. Annual Report

A. On or before July 1 of each year, the executive director shall cause to be prepared an annual statement of the financial condition of the fund at December 31 of the preceding year, which statement shall be substantially in the form of the annual report required to be filed by liability insurance companies authorized to do business in this state, and which statement shall have been audited or reviewed by the legislative auditor or by an independent certified public accountant. Such statement shall be submitted to the governor, the board, and the legislature on or before July 1 of each year, and shall be a public record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 19:204 (February 1993).

Chapter 14. Medical Review Panels

§1401. Procedure

A. Except as otherwise provided by the Act, all malpractice claims against health care providers shall be reviewed by a medical review panel. The composition and operation of a medical review panel shall be in accordance with R.S. 40:1299.47.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

§1403. Malpractice Complaint

A. A "request for review of a malpractice claim" or "malpractice complaint" shall contain, at a minimum:

1. a request for the formation of a medical review panel;
2. name of the patient;
3. name(s) of the claimant(s);
4. name(s) of defendant health care providers;
5. date(s) of alleged malpractice;
6. brief description of alleged malpractice; and
7. brief description of alleged injuries.

B. The request for review of a malpractice claim shall be deemed filed on the date of receipt of the complaint stamped and certified by the board or on the date of mailing of the complaint if mailed to the board by certified or registered mail.

C. Within 15 days of receiving a malpractice complaint, the board shall:

1. confirm to the claimant that the malpractice complaint has been officially received and whether or not the named defendant(s) are qualified for the malpractice claim; and
2. notify all named defendant(s) that a malpractice complaint requesting the formation of a medical review panel has been filed against them and forward a copy of the malpractice complaint to each named defendant at his last and usual place of residence or his office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

§1405. Attorney Chairman

A. An attorney chairman of a medical review panel is to be chosen by the parties according to R.S. 40:1299.47.C. An attorney chairman must be secured within two years from the date the request for review of the claim was filed. If, after two years, an attorney chairman has not been secured, the board shall send notice by certified mail to the claimant or the claimant's attorney stating that the claim will be dismissed after 90 days if no attorney chairman is appointed. If no attorney chairman is appointed within 90 days of the certified notice, the board shall dismiss the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

Chapter 15. Defense of the Fund

§1501. Claims Defense

A. Through its executive director, the board shall be responsible for the administration and processing of claims against and legal defense of claims against the fund. The executive director shall be responsible, and accountable to the board, for coordination and management of defense of the fund against claims to the extent of the responsibilities imposed on the board by the Act. Without limitation on the scope of such responsibility, the executive director shall be specifically responsible for:

1. evaluating all malpractice claims made under the Act against enrolled health care providers to the potential liability of the fund;
2. recommending, fixing, establishing, and periodically modifying, as required, appropriate reserves against claims made against enrolled health care providers or the fund, subject to the approval of the board;
3. retaining, subject to qualifications and standards prescribed by the board, and supervising the services of attorneys at law to defend the fund against claims;
4. review and approval of fee and costs statements for services rendered by attorneys at law retained to defend the fund, ensuring that such statements accurately reflect services reasonably necessary or appropriate to the defense of the fund;
5. supervision and coordination of the defense of claims against or involving the fund by attorneys retained and representing enrolled health care providers;
6. negotiating and recommending reasonable and appropriate compromises and settlements of the fund's liability respecting any claim against the fund;
7. maintenance of current, accurate, and complete records and data on all pending and concluded claims against or involving the fund; and
8. the discharge and performance of such other duties, responsibilities, functions, and activities as are delegated by the board;
9. all authority for the defense of the fund vested in the board by the Act is hereby delegated to the executive director. In the exercise of such authority, the executive director shall be accountable to, and subject to the superseding authority of, the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003).

§1503. Claims Accounting

A. All expenses incurred in the legal defense, disposition, payment on individual claims, judgments, or

settlements shall be accounted for and allocated among such respective claims.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003).

§1505. Claim Reserves

A. Within 10 days of receipt of notice of a claim against or potentially involving liability of the fund, the fund shall establish a reserve against such claim representing the total amount of compensation and compensation adjustment expenses which the fund is anticipated to be liable for and incur in respect of and allocable to such claim. Reserves respecting individual claims against the fund shall be established in consultation, as appropriate, with legal counsel representing the fund with respect to such claim, with legal counsel for the enrolled health care providers against whom the claim is primarily asserted, and with claims personnel managing such claim for the commercial insurers of the enrolled health care providers against whom the claim is asserted. Reserves respecting individual claims against the fund shall be adjusted from time to time as changing circumstances or evaluations may warrant, and all reserves shall be reviewed not less frequently than quarterly for necessary and appropriate adjustments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003).

§1507. Settlement of Claims

A. Claims against the fund may be compromised and settled upon the recommendation of the executive director and the approval of the board. The executive director shall, however, have authority, without the necessity of prior approval by the board, to compromise and settle any individual claim against the fund for an amount not exceeding \$10,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003).

§1509. Privileged Communications, Records

A. All communications made and documents, records, and data developed between, by, or among the board, executive director, Office of Risk Management, PCF general counsel, contracted legal counsel, and enrolled health care providers and their insurers respecting malpractice claims asserted against enrolled health care providers or the fund shall be deemed privileged and confidential and, unless so ordered by a court of competent jurisdiction after a contradictory hearing, shall not be disclosed to any third party pursuant to request, subpoena, or otherwise, without the express written authorization and consent of the person, office, or entity making any such communication or

originally possessing any such documents, records, or data. This rule shall not, however, prohibit disclosure or publication by the board of aggregated information or data from which information or data relative to individual health care providers or individual claims may not be discerned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

Chapter 17. Transitional Rules

§1701. Continuing Enrollment of Self-Insureds

A. A health care provider who or which is duly qualified and enrolled with the fund as a self-insured provider on and as of the effective date of these rules shall not be required to comply with the provisions of §507 of these rules respecting the amount and type of evidence of financial responsibility until:

1. 180 days from the effective date of these rules; or
2. the date on which such provider's enrollment with the fund next expires, and the provider seeks renewal of such enrollment, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

§1703. Continuing Enrollment of Self-Insurance Trusts

A. A health care provider who or which is duly qualified and enrolled with the fund as a self-insurance trust on and as of the effective date of these rules shall not be required to comply with the provisions of §509 hereof respecting the approval of self-insurance trusts and demonstration of financial responsibility until:

1. 180 days from the effective date of these rules; or
2. the date on which such trust's enrollment with the fund next expires, and the trust seeks renewal of such enrollment, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

Chapter 19. Future Medical Care and Related Benefits

§1901. Scope of Chapter

A. The rules of Chapter 19 provide for and govern the administration and payment by the fund of future medical care and related benefits for patients deemed to be in need of future care and related benefits pursuant to a final judgment issued by a court of competent jurisdiction or agreed to in a settlement reached between a patient and the fund.

B. The rules of Chapter 19 shall be applicable to all malpractice claims, including those brought under R.S. 40:1299.39.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1903. Definitions

Future Medical Care and Related Benefits—all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services, and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services. The fund's obligation to provide these benefits or to reimburse the claimant for those benefits is limited to the lesser of the amount billed therefor or the maximum amount allowed under the reimbursement schedule.

Reimbursement Schedule—the most recent reimbursement schedules promulgated by the Department of Labor, Office of Workers' Compensation pursuant to R.S. 23:1034.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1905. Obligation of the Fund

A. The fund shall provide and/or fund the cost of all future medical care and related benefits in the amounts provided herein, after the date of the accident and continuing as long as medical or surgical attention is reasonably necessary, that are made necessary by the health care provider's malpractice, pursuant to a final judgment issued by a court of competent jurisdiction or as agreed to in a settlement reached between a patient and the fund, unless the patient refuses to allow the future medical care and related benefits to be furnished.

B. The fund acknowledges that a court is required neither to choose the best medical treatment nor the most cost-efficient treatment for a patient. The intent of Chapter 19 is to distinguish between those devices which are reasonably necessary to a patient's treatment and those which are devices of convenience or non-essential specialty items for a patient, and to provide for the maximum allowable reimbursement for those necessary future medical care and related benefits.

C. Pursuant to the Act, the board has been, expressly and/or implicitly, vested with the responsibility and authority for the management, administration, operation, and defense of the fund and, as a prudent administrator, it must insure that all future medical care costs and related benefits are reasonable and commensurate with the usual and customary costs of such care in the patient's community. Therefore, the amount paid by the fund for future medical care and related

benefits shall be the lesser of the amount billed for said care or benefit or the maximum amount allowed under the reimbursement schedule.

D. Payments for future medical care and related benefits shall be paid by the fund without regard to the \$500,000 limitation imposed in R.S. 40:1299.42.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1907. Claims for Future Medical Care and Related Benefits

A. A patient, who is deemed to be in need of future medical care and related benefits pursuant to a final judgment issued by a court of competent jurisdiction or as agreed to in a settlement reached between the patient and the fund, may make a claim to the fund through the board for future medical care and related benefits made necessary by the health care provider's malpractice.

B. If a patient's claim for future medical care and related benefits is extremely complex, is disputed or is in excess of the reimbursement schedule, then the fund may refer the matter to medical or other experts or to its counsel for review or litigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001).

§1909. Attorneys; Medical Experts; Architects; Adjusters

A.1. An attorney chosen to represent the fund pursuant to §1907 shall be an independent contractor of the state of Louisiana, shall meet all applicable requirements for an outside contractor retained by the state of Louisiana, and shall be chosen by the risk director (or his successor) or his designee. The attorney shall be licensed to practice law in the state of Louisiana.

2. Once a matter involving future medical care and related benefits is referred to an attorney pursuant to §1907, then the attorney shall be responsible for the matter to the extent of the assignment (i.e., investigation and/or litigation of a particular claim, issue or request). The attorney shall issue status reports to the claims supervisor at least every 90 days until the matter is concluded.

3. The attorney chosen to represent the fund pursuant to §1907 may recommend any and all possible remedies to the fund, including litigation of any kind, and may hire or retain experts, subject to prior approval by the fund. The attorney shall utilize legal staff, including paralegals, nurse/paramedical personnel, clerks, and investigators, where necessary. With prior approval from the claims

supervisor, the attorney may appoint a case manager in cases where no case manager has been appointed.

B. Pursuant to §1907, medical experts may be retained directly by the fund for evaluation, diagnosis, or with patient consent or by court order, for treatment of the patient. All medical experts retained by the fund shall be licensed or otherwise certified by the state of Louisiana. However, consulting physicians, licensed to practice in states other than Louisiana, may be retained by the fund only if they are board-certified in the applicable area of specialty.

C. Pursuant to §1907, architects with special expertise in medical facility design, contractors, and other building trade experts may be retained directly by the fund in future medical care cases involving issues of residential modifications or renovations. Architects retained by the fund shall be licensed by the state of Louisiana. Contractors retained by the fund shall be licensed or certified as general contractors by the state of Louisiana. Architects and contractors retained by the fund shall also possess experience in the design and construction of medical facility and/or barrier free residences.

D. Pursuant to §1907 and subject to fund approval, adjusters may be retained as independent contractors on the recommendation of the claims manager or of the attorney chosen to represent the fund pursuant to §1907.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001).

§1911. Examinations; Notice Requirements

A. The fund shall be entitled to have a patient submit to a physical or mental examination, by a health care provider of the fund's choice, from time to time, to determine the patient's continued need of future medical care and related benefits, subject to the following requirements.

1. Notice, in writing, shall be delivered to or served upon the patient or the patient's counsel of record, specifying the time and place where the examination will be conducted. Delivery of the notice may be by certified mail or by hand delivery. Such notice shall be given at least 10 days prior to the time stated in the notice.

2. The place at which the examination is to be conducted shall not involve an unreasonable amount of travel for the patient, considering all of the circumstances.

3. It shall not be necessary for a patient who resides outside of Louisiana to come to this state for an examination, unless so ordered by the court.

4. The examination shall be conducted by a health care provider licensed by the state of Louisiana or by the state wherein the patient resides.

B. Examinations may not be required by the fund more frequently than at six-month intervals except that, upon

application to the court having jurisdiction of the claim and for reasonable cause shown therefor, examinations within a shorter interval may be ordered.

C. Within 30 days after the examination, the patient shall be compensated, by the party requesting the examination, for all necessary and reasonable expenses incidental to submitting to the examination, including the reasonable costs of travel, meals, lodging, or other direct expenses as provided elsewhere in these regulations.

D. The patient shall be entitled to have a health care provider or an attorney of his choice, or both, present at the examination. The patient shall pay such health care provider or attorney himself.

E. The patient shall be promptly furnished with a copy of the report of the examination made by the health care provider conducting the examination on behalf of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1913. Choice of Health Care Provider

A. A patient entitled to future medical care and related benefits, as determined under Chapter 19, shall be entitled to evaluation, diagnosis, and treatment by the health care providers of the patient's choice provided, however, that the health care provider rendering such evaluation, diagnosis, or treatment shall be licensed to practice medicine in Louisiana or by the state in which the patient resides. Notwithstanding the patient's right to choose his health care provider, the amount which the fund shall be required to pay or reimburse any healthcare provider shall be the lesser of the provider's billed amount or the reimbursement schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1915. Psychological /Psychiatric Treatment and Counseling

A. The fund will provide and/or fund, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule, psychiatric/psychological testing, evaluation, diagnosis and treatment of a patient entitled to future medical care and related benefits, as determined under Chapter 19, where these medical services are reasonable and are made necessary by the health care provider's malpractice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1917. Nursing Care; Sitter Care

A. The fund will provide and/or fund, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule, inpatient or outpatient nursing or sitter care when such care is required to provide reasonable medical, surgical, hospitalization, physical rehabilitation, or custodial services made necessary by the health care provider's malpractice, subject to the following limitations.

1. All nursing or sitter care shall be specifically prescribed or ordered by a patient's treating health care provider.

2. All nursing or sitter care shall be rendered by a licensed and/or qualified registered nurse or licensed practical nurse or by a sitter, a member of the patient's family or household, or other person as specifically approved by the fund.

3. There shall be a presumption that the person rendering nursing or sitter care is qualified if the treating health care provider issues a statement that that person is competent and qualified to render the nursing or sitter care required by the patient.

4. All claims for nursing or sitter care payments must include a signed, detailed statement by the person rendering nursing or sitter care, setting forth the date, time, and type of care rendered to and for the patient.

B.1. Providers of nursing or sitter care shall be funded, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule. If the reimbursement schedule contains no applicable rate for such care, then the care shall be funded at the lesser of the billed amount or the usual and customary rate charged by similarly licensed or qualified healthcare providers in a patient's home state, city, or town. However, nursing or sitter care provided by members of the patient's family or household will be funded at a rate not to exceed \$6 per hour regardless of the licensure or qualification of the provider.

2. However, notwithstanding the foregoing, future nursing or sitter care provided, after the effective date of the amended rules which provide for inflationary adjustments, by members of the patient's family or household will be funded at a rate not to exceed the equivalent of \$6 per hour plus inflation at the annual consumer price index published by the United States Bureau of Labor Statistics for each year between the year of original publication of the rate (1993) and the date of service, regardless of the licensure or qualification of the provider.

C. The fund shall be entitled to periodic inspections or assessments of the physical environment in which the nursing or sitter care is being rendered. The fund may seek a judicial ruling to discontinue the payments for future medical care and related benefits if, upon inspection and recommendation of a licensed or qualified health care provider, it is determined that the physical environment in which the nursing or sitter care being rendered is inadequate or inappropriate and not in the best interest of the patient.

D. The fund may seek a judicial ruling to discontinue the payments for future medical care and related benefits if, upon a physical or mental examination of the patient, pursuant to §1911, and recommendation of a licensed or qualified health care provider, it is determined that the nursing or sitter care being rendered is inadequate or inappropriate and not in the best interest of the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1919. Treatment Protocol

A. In cases where the future medical needs of the patient are so great that multi-disciplinary, long-term acute care is needed by the patient, and the patient and/or the patient's family, tutor, legal guardian or care givers are deemed to be incapable of determining what treatment is necessary, then the fund may obtain or develop a treatment protocol for the patient. The patient will be provided with a copy of the written treatment protocol and will be asked to consent to the treatment or course of treatment proposed by the protocol prior to implementation of the protocol.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1921. Vehicles

A. The fund will provide and/or fund the cost of standard modified vehicles or specialized modified vehicles to patients entitled to receive future medical care and related benefits under §1921, when ownership and use of such vehicles are reasonably necessary in providing reasonable medical, surgical, hospitalization, physical rehabilitation, or custodial services made necessary by the health care provider's malpractice. The vehicles described herein are standard model, modified passenger vehicles of domestic manufacture or standard model, modified vans of domestic manufacture. Alternatively, and at the fund's option, the fund will provide and/or fund modifications to the patient's vehicle when such modifications are reasonably necessary in the provision of such services.

B. The choice of vehicle, vendor of the vehicle, modifications thereto, and inclusion or exclusion of option items on these vehicles will be at the sole discretion of the fund.

C. The fund will not provide nor fund the cost of any type of insurance for any such vehicle and will not provide nor fund the maintenance or operating costs on any vehicle modified by the fund or provided by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1923. Ancillary Cost; Mileage

A. The fund will reimburse a patient (or the patient's family or care givers) entitled to future medical care and related benefits under §1923 for actual out-of-pocket ancillary costs of medical treatment and/or care to the patient including, but not limited to, the actual costs of over-the-counter medicines and patient aids, the reasonable costs of hotel/motel accommodations and meals associated with physician appointments or treatment, when such costs are made necessary by the health care provider's malpractice.

B.1. Vehicle Not Provided by the Fund. The fund will reimburse a patient (or the patient's family or care givers) entitled to future medical care and related benefits under §1923 for actual mileage to and from physician appointments or treatment at a rate not to exceed \$0.24 per mile or the current mileage rate allowance under applicable state guidelines.

2. Vehicle Provided by the Fund

a. Fund Reimbursement. Notwithstanding Paragraph B.1 or §1921.C, above, when the fund has furnished the vehicle to a patient, the fund will reimburse that patient (or that patient's family or care givers) who is entitled to future medical care and related benefits under §1923, for actual mileage to and from physician appointments or other testing or treatment, at a rate equal to 50 percent of the then applicable mileage rate.

b. Fund Credit for Non-Covered Usage. When the vehicle has been provided by the fund and the fund is required to reimburse for medically-related usage, the fund shall, however, be entitled to a credit, at the same mileage rate, for any use of the vehicle which is not eligible for reimbursement.

C. The level of expense reimbursement pursuant to §1923 shall not exceed the maximum allowable expenses under applicable state guidelines set forth in the Travel Regulations, P.P.M. 49, Louisiana Register, Vol. 16, Number 7, p. 582 or, in the case of reimbursement under Paragraph B.2 above, 50 percent of that amount.

D. Patients shall provide actual receipts or signed statements verifying the reasonable mileage for odometer readings to receive reimbursements pursuant to §1923. Expenses for hotel /motel accommodations and meals associated with physician appointments or treatment shall not be reimbursed without prior approval by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended LR 27:1889 (November 2001).

§1925. Modifications/Renovations to Patient's Residence

A. The fund will provide and/or fund the cost of modifications to a patient's residence which are reasonably necessary in providing reasonable medical, physical

rehabilitation, and custodial services for the patient and which are made necessary by the health care provider's malpractice. The fund will not provide nor fund the cost of devices of convenience.

B. The patient may be required to submit to a medical examination by a medical expert selected by the fund to specifically determine the patient's needs as they relate to the home. Upon completion and receipt of the medical expert's report, the patient and/or the patient's family or care givers will then be consulted by the case manager to determine specifically what modifications should be made to the home. The case manager, the fund's claims' supervisor, the claims' manager, the attorney for the fund, if one is selected, and the architect chosen by the fund will then review the report(s) of the medical expert(s) and the case manager, and then meet to determine what action will be taken as to the modifications of the home, within the specific guidelines listed below.

1. The fund will provide and/or fund the cost of modifications or renovations to the patient's existing home including, but not limited to, modifications of lavatories, including handicap accessible toilets, showers, ramps for ingress and egress, expanded doorways, and expansion of rooms to accommodate medical devices required by the patient, which are reasonably necessary for the care and rehabilitation of the patient.

2. All renovations and/or modifications will be designed and built with builders spec or similar grade materials from plans drawn and/or approved by an architect obtained by the fund.

3. When the fund has provided and/or funded modifications or renovations to the home where the patient resides, the fund shall retain no interest in that residence. Where the home is owned by the patient's parents, relatives, care givers, or guardian, the fund reserves the right to require the owners of the home to execute a promissory note, mortgage, or other instrument of security in favor of the patient in an amount equal to the increased value of the home, as determined by a qualified appraiser retained by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1927. Testimony; Communications

A. Any health care provider selected and paid by the fund who shall make or be present at an examination of the patient conducted pursuant to §1911 may be required to testify as to the conduct thereof and the findings so made.

B. Communications made by the patient during the examination conducted pursuant to §1911 by the health care provider shall not be considered privileged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1569 (December 1993).

§1929. Fees and Costs

A. The fund shall pay all reasonable fees and costs of examinations, including the costs and fees of expert witnesses in any proceeding, where termination of medical care and related benefits is sought.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1569 (December 1993).

§1931. Attorney Fees

A. Pursuant to its continuing jurisdiction, the district court, from which a final judgment has been issued in cases where future medical care and related benefits have been determined to be needed by a patient, shall award reasonable attorney fees to the patient's attorney if the court finds that the fund unreasonably failed to pay for medical care and related benefits within 30 days after submission of a claim for payment of such benefits.

B. A patient and/or the patient's attorney shall not be entitled to attorney fees in any action to enforce rights pursuant to §1931.A if the patient fails or refuses to submit to examination in accordance with a notice and if the requirements of §1911 have been satisfied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 9:1569 (December 1993).